MEETING SUMMARY
RURAL & FRONTIER HEALTHCARE SOLUTIONS WORKGROUP MEETING

Thursday, June 24, 2020 | 2:00 p.m. – 3:00 p.m. MST
Virtual Meeting

Participants

Members: Abner King, Christina Thomas, Darin Dransfield, Hilary Klarc, Jake Erickson, Janet Reis, Lenne Bonner, Linda Rowe, Patt Richesin

Guests: Tyler Freeman

Staff: Stephanie Sayegh, Mary Sheridan, Ann Watkins, Susan Heppler, Matt Walker

Facilitators: Elizabeth Spaulding, Anna Wiley

Welcome & Introductions

Elizabeth Spaulding, facilitator, began the meeting with an overview of meeting goals, virtual meeting procedures, and the meeting agenda. Jake Erickson motioned to approve the May 2020 meeting minutes; Darin Dransfield seconded the motion.

Additionally, Patt Richesin gave a brief update regarding the effort to schedule a time to speak with the new director of CMMI and representatives from states that have undergone statewide Medicaid innovation initiatives to learn from their experiences.

Update on Previous Action Items

The workgroup briefly discussed the logic model that was discussed at an earlier meeting with Dr. Craig Jones, especially related to governance and education in an innovation model. It was agreed upon that a governance model was an important piece of the potential Idaho model, and both Patt Richesin and Mary Sheridan will reach out to their contacts to locate example governance models.

Readiness Report & Data Update

Before the meeting, the workgroup was sent out a copy of both a Value-Based Readiness Report ("VBC Tool") and a CAH Profitability Indicators data pull. The Value-Based Readiness Report was shared with the group to determine whether to ask potential model participants to complete the assessment process. From the hospitals that have completed the assessment, it was deemed an informative and useful tool that could help the workgroup drive focus and identify issues that need to be addressed. A

handful of hospitals that have not completed the assessment will attempt to do so by the end of summer.

The profitability indicators data was briefly discussed, but specific questions will be addressed by Larry Tisdale before the next meeting:

- How are small/medium/large hospitals defined?
- If based on revenue, is it based off gross revenue?
- What indicators are most important to determine the “state-of-the-state"?
    - Payer mix, capital expenditures, etc.

Patt will use this data to compare the state of Idaho CAH’s to other states to determine similarities and differences to consider when creating the Idaho model.

Additionally, Mary Sheridan and Tyler Freeman have been in conversations with Medicaid to gather data points. Medicaid will create a report based on Healthy Connections data for the workgroup. Mary and Tyler are also working with Linda Rowe’s team to gather more granular data.

Action Items and Next Steps

Action Items:

- Assessment Tool
    - “Why” statement for Assessment Tool – Larry Tisdale
    - Check in with Hospitals completing assessment
- Idaho Model
    - Develop vision statement
    - New sections: Data, governance, and education - Patt and DHW to reach out to their contacts for examples
    - Logic model – Dr. Craig Jones?
- Data
    - Medicaid Data – Mary and Tyler
    - Determine data points – Patt Richesin and team
    - Blue Cross data – Lenne Bonner
    - Data from payers? – Hilary Klarc
- Outside Expert?
    - Think about experts that could be brought into the group.
        - Hilary Klarc - Jennifer Yturriondobeitia with Cornerstone Whole Healthcare Organization

Rural and Frontier Healthcare Solutions Workgroup

Next Steps for Medicaid Payment for Value

July 27, 2020

IDAHO DEPARTMENT OF HEALTH & WELFARE

Medicaid Goals for Value Based Payment

Measurably improve the health of Idahoans with Medicaid coverage.

Reward providers who deliver high quality and cost-efficient care.

Stabilize and control Medicaid spending.

Background – HCVC Program

Healthy Connections Value Care (HCVC) Program established.

Voluntary accountable care program developed to move away from traditional volume-based payment to value-based payments that provides both incentives and disincentives related to health outcomes and targeted cost trends.

Providers currently under HCVC contract

3 – Accountable Primary Care Organizations

- 20, 709 lives covered
- 25 Service Locations

2 – Accountable Hospital Care Organizations

- 72,449 lives
- 95 Service Locations

Implementation delayed to 7/1/21 due to coronavirus impacts

Data work, development, and information sharing ongoing

Background – HB 351

Legislation passed in 2020 session requiring DHW to:

- Establish value-based payment methods for hospital (except critical access) and nursing facility services effective 7/1/21 to replace existing cost-based reimbursement methods
- Establish a quality payment program to replace current supplemental payments (upper payment limit) to hospitals
- Reduce hospital reimbursement and increase nursing facility assessments in SFY 2020 and SFY 2021

Desire by Hospitals to align quality payment program for UPL with the broader HCVC approach:

- Enrollment in a Value Care Organization would be based on selection/attribution of primary care provider
- Calculation of total cost of care would remain mostly the same

Background - Medicaid needs

- Implement hospital and nursing facility changes by next July
  - Ongoing meetings with hospital and nursing facility representatives
- Control costs for the Medicaid program by improving care
  - Care for people who are healthy costs less than care for those who are sick
  - Reimbursement needs to align with health rather than procedures
  - Care management needs to be consistent and effective
  - Even more important now because of increased growth due to expansion, coronavirus economic impacts, and the decline in state revenues
- Meet the challenge of developing broad based value based payment
  - Data and analytic needs are intensive
  - Actuarial work can be costly
  - Time is short
  - Staff resources and funding are limited
  - Supporting multiple efforts is not feasible

VBP RFI Responses

26 Responses Received

- Healthy Connections Organizations
- Hospital Integrated Networks
- Provider Networks
- Professional Organizations
- Other Payers
- Health Plans
- Medical Management Companies
- Health Districts

VBP RFI Themes: General Themes

- HCPLAN Alternative Payment Models (APMs) is proven and logical path for the Dept. to pursue
- Dept. should consider a ramp up and learning period before a provider is required to accept risk
- Small and rural practices must be supported in forming larger group affiliations as they do not have the attributed lives or infrastructure/resources to assume risk
- To be successful VBP model must address behavioral health and social determinants of health as well as physical health needs
- Minimum requirement of 10,000 attributed lives should be considered to effectively impact change
- Consider mandatory enrollment in regional or statewide ACO's to achieve desired cost and quality outcomes

VBP RFI Themes: General Themes

- A focus solely on VBP transformation without a comprehensive Medicaid payment reform strategy could result in unintended outcomes
- Aligning incentives, performance measures and risk methodologies across payers would yield best results
- VBP arrangements will be most successful if supported by a multi-disciplinary Dept. team
- Providing concrete goals is vital to provider success in value-based care
- Dept's ability to provide reliable, timely performance data is critical to VBP success
- Look to other successful program experience as a guide to success

Our perspective

1. We need a single statewide approach
   - Everyone's efforts are more successful when they are focused
   - Medicaid does not have bandwidth to support multiple programs
   - Coordination with other payers is easier under a single program
   - Measuring quality and efficiency requires adequate numbers to be meaningful
   - Participation at some level would be necessary for all primary care and hospital providers (excluding critical access hospital, at least to begin with)
2. Risk is necessary but must be scaled
   - Medicaid budget control is not optional at this point and we need risk partners to achieve it
   - Provider capabilities for managing risk vary
   - We need to recognize those limitations and address them within our value based payment structure to be successful
3. To move forward we need to build on past achievements
   - Use the existing and familiar Healthy Connections patient enrollment structure
   - Use the total cost of care definition developed under HCVC for shared savings/risk

Our perspective

4. Medicaid will need to change
   - Increased investment in data and analytics
   - Shift from a regulatory mindset to a contract partnership orientation
   - Increased accountability for budget and reimbursement management
5. We need to build a structure that will support future growth
   - We won't be able to do everything at once
   - Critical access hospitals and behavioral health providers won't be included at first
   - We need to consider how to involve those providers for the future
   - Social determinants of health and managed care intersections should also be considered
6. We need stronger primary care partnerships
   - Between Medicaid and primary care providers of all sizes and structures
   - Between hospitals and primary care providers
   - Between primary care and behavioral health providers